Adult Information Form

Client Name:_____ Age:____ DOB:_____ Date:_____
Address:_____ City:_____ State:___ Zip:_____
Home Phone: ( )_____ OK to leave message? __Yes __No
Work Phone: ( )_____ OK to leave message? __Yes __No
Current Employer (or school if a student):_____
Gender: __Male __Female Who referred you here? _____

WHO MAY WE CONTACT IN CASE OF EMERGENCY?
Daytime Phone: ( )_____ Evening Phone: ( )_____
Spouse's Name (if applicable): _____ Age:_____ DOB:_____

Current Marital Status
__Single (duration: _____) __Married (duration: _____)
__Cohabiting (duration: _____) __Separated (duration: _____)
__Divorced (duration: _____) __Widowed (duration: _____)

Education
Currently in school: ___Yes ___No Total years of education: _____
__High School Graduate
__G.E.D. Major area(s) of study/training
__Vocational: # of years ___ Graduated: ___Yes ___No _____
__College: # of years ___ Graduated: ___Yes ___No _____
__Grad. School: # of years ___ Graduated: ___Yes ___No _____
Special Services? (Special education, learning disabilities, etc) _____

Employment
Are you currently employed? ___Yes ___No
Current Employer: _____ Job Title: _____
Length of time employed: _____ Job responsibilities: _____
Level of stress of job: _____ Other jobs you have worked:

Legal
Are you involved in any legal activities (civil, criminal, custody, probation/parole, etc.)? __Yes __No
If yes, please describe:
Past History:
Traffic violations: ___Yes ___No DUII/DWI, etc: ___Yes ___No
Felony/Misdemeanor charges? ___Yes ___No Civil/custody lawsuits: ___Yes ___No

Military Experience
Military experience? ___Yes ___No (If no, skip this section)
Branch of Service: _____ Date enlisted/drafted:
Discharge date: _____ Type of discharge: _____ Rank at discharge:
Combat experience? ___Yes ___No Other stressors experienced:

Therapist Notes:

Adult Information Form

PRESENTING PROBLEMS/CONCERNS

Describe the problem that brought you here today:

What do you hope to gain from therapy:

Please check behaviors and symptoms that occur to you more often than you would like:

___ Aggression/fighting	___ Dizziness	___ Irritability	___ Sleeping problems
___ Alcohol abuse	___ Drug abuse	___ Judgment errors	___ Speech problems
___ Angry outbursts	___ Eating disorder	___ Loneliness	___ Suicidal thoughts
___ Arguments/conflicts	___ Elevated mood	___Memory impairment	___ Thoughts disorganized
___ Anxiety	___ Fatigue	___ Mood swings	___ Trembling
___ Avoiding people	___ Gambling	___ Panic attacks	___ Withdrawing
___ Chest pain	___ Hallucinations	___ Phobias/fears	___ Worrying
___ Computer addiction	___ Heart palpitations	___ Recurring thoughts	___ Other (specify):
___ Depression	___ High blood pressure	___ Sexual addiction	
___ Disorientation	___ Hopelessness	___ Sexual difficulties	
___ Distractibility	___ Impulsivity	___ Frequent illness	

Briefly describe how the above checked symptoms impair your ability to function effectively:

Have you ever had thoughts or made statements of wanting to hurt yourself or seriously hurt someone else? ___Yes ___No. If Yes, please describe the situation:

Have you ever purposely hurt yourself or another? ___Yes ___No. If Yes, please describe situation:

PRIOR MENTAL HEALTH TREATMENT

Type of Treatment	No	Yes	Start/End dates	Provider name/primary reason for treatment
Counseling or Psychiatric Care				
Drug/Alcohol Treatment				
Medication for mental health problem				
Self-help/support group				

Therapist Notes:

Adult Information Form

FAMILY & DEVELOPMENTAL HISTORY

Relationship	Name	Age	Deceased Y - N	Quality of Relationship	Family mental health problems?	Who?
Mother					Depression	
Father					Anxiety	
Stepmother					Sexual abuse	
Stepfather					Attention deficit	
Spouse/partner					Alcohol abuse	
Children					Drug abuse	
					Schizophrenia	
					Manic-depression	
					Imprisonment	
Siblings					Suicide	
					Eating disorders	
					Panic attacks	
					Obsessive/ compulsive	

Parental Marital Information:

___ Parents legally married
___ Parents have been separated
___ Parents divorced
___ Mother remarried: Number of times
___ Father remarried: Number of times

Is there anything happening NOW in your current living situation or in your family that is especially stressful for you?

Please check if you have suffered any of the following types of trauma:

___ Neglect
___ Sexual abuse
___ Teenage pregnancy
___ Violence in the home
___ Parental illness
___ Multiple family moves
___ Emotional abuse
___ Loss of a loved one
___ Parental substance abuse
___ Parents separated or divorced
___ Homelessness
___ Other
___ Physical abuse
___ Natural disaster
___ Crime victim
___ Financial problems
___ Lived in a foster home

Please comment on any of the above checked items (including your age when the trauma occurred and the details of the traumatic event):

Therapist Notes:

Adult Information Form

CHEMICAL USE HISTORY

Substance Type	Current Use (within the last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijauna								
Cocaine/crack								
PCP/LSD								
Heroin/opiates								
Methamphetamines								
Inhalants								
Other								

Have you had withdrawal symptoms when trying to stop using any substances? ___Yes ___No. If yes, please describe the situation:

Have any substances created a problem for you at work or home? ___Yes ___No. If yes, please describe the situation:

Therapist Notes:

SOCIAL/CULTURAL HISTORY

Please check how you generally get along with other people: (check all that apply)

___ Affectionate ___ Aggressive ___ Assertive ___ Avoidant ___ Follower
___ Fight/argue often ___ Leader ___ Outgoing ___ Shy/withdrawn ___ Submissive

Describe special areas of interest or hobbies (i.e., art, books, crafts, physical fitness, etc.)

Activity	How often now?	How often in the past?

Please describe your strengths, skills and talents:

To which cultural or ethnic group do you belong?
Are you experiencing any difficulties due to cultural or ethnic issues? If yes, please describe:

How important are spiritual matters to you? ___ Not at all ___ Little ___ Somewhat ___ Very much
Are you affiliated with a particular spiritual or religious group? ___ Yes ___ No. If yes, please describe:
Would you like your spiritual/religious beliefs incorporated into the counseling? ___ Yes ___ No

MEDICAL INFORMATION

Current Physician: _____ Phone: _____
Physician's Address: _____
When was your most recent complete physical examination? _____

Have you suffered from any of the following medical conditions during your lifetime?

___ A serious accident	___ Surgery	___ Allergies
___ A head injury	___ Meningitis	___ Hospitalizations
___ High fevers	___ Hearing problems	___ Headaches
___ Vision problems	___ Asthma	___ Loss of consciousness
___ Ear infections	___ High blood pressure	___ Pregnancy/miscarriage
___ Stomach aches	___ Diabetes	___ Speech/language problems
___ Abortion	___ Chronic pain	___ A sexually transmitted disease
___ Cancer	___ Heart problems	___ Thyroid problems
___ Seizures	___ Other _____	___ Other

Please describe any checked items, noting your age at the time of onset:

List any current health concerns:

Current medications: ___ None

Medication	**Dosage**	**Date First Prescribed**	**Prescribed By**

Current over-the-counter medications: (please include vitamins, herbal remedies, etc.)

Allergies and/or adverse reactions to medications:

Therapist Notes: